

Report of Youth Suicide Attempts

The Incident:

Date of Incident: ____/____/____

Type: ____ Suicide Attempt
____ Suicide Completed

____/____/____
(today's date)

Geographical location of incident: Municipality: _____

County: _____

Where did the suicide attempt occur?: (e.g., own home, school, park, etc.): _____

What method was used?: (e.g., hanging, pills, cutting) _____

Was there any evidence of drug and/or alcohol consumption? Yes___ No___ Unk___

Information about the victim:

Age: _____

(estimate if unk)

Race(check all that apply):

Asian: _____

African American: _____

Hawaiian/Pacific Islander: _____

Native American _____

White: _____

Other (identify) _____

Unknown _____

Gender:

Female: _____

Male: _____

Hispanic/Latino Origin:

Yes___ No___ Unk___

Any known prior suicide attempts?

Yes___ No___ Unk___

Any known family history of suicide attempt?

Yes___ No___ Unk___

Sexual orientation/identity issues?

Yes___ No___ Unk___

If attempted suicide was not completed, was victim:

sent to clinic or hospital for medical treatment?

Yes___ No___ Unk___

hospitalized?

Yes___ No___ Unk___

referred for mental health or psychiatric counseling?

Yes___ No___ Unk___

Other services offered: _____
(describe)

Information about you:

Are you a licensed or certified professional?

Yes: _____

➔ What profession? _____

No: _____

Relationship of victim to you or your employer: _____

If you would like information about services in your area, please indicate how we can contact you:

Your Name: _____

Agency: _____

Mailing Address _____

Telephone: (____) - ____ - _____

eMail: _____

Please mail the completed form to :

YSA
NJ DMHS
PO Box 727
Trenton, NJ 08625-0727

OR FAX to (609) 777-0835